NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC POST TREATMENT SUMMARY

Date:_____

Return this letter to:

EDS Prior Approval Unit
Attn: Orthodontic Review Board
P.O. Box 31188
Raleigh, NC 27622

Recipient name: _____

Medicaid ID #: _____

Prior approval #:_____

Active phase of treatment has been completed. Date of debanding: _____

Results obtained (please circle): excellent good fair poor

Assessment of recipient cooperation: excellent good fair poor

Comments: _____

_____

_____

Number of paid maintenance visits: _____

Provider number: _____

Provider name: _____

Provider address: _____

_____

Provider phone: _____